Synchronous intrauterine and ectopic pregnancy

A report on two cases

M. GRAMPA - A. ERCOLI - M. ROSSINOTTI

Key word: Combined pregnancy.

CASE 1

In December 1978 a 28 year old woman came as an emergency admission to our department complaining of abdominal pain, slight bleeding p.v. and 9 weeks amenorreha.

The obstetric history was positive for 2 previous full term pregnancies and a first trimester miscarriage of a twin pregnancy.

On vaginal examination the uterus was gravid, in size 9 weeks, the cervical os was close and a tender mass was felt in the left iliac fossa.

The vital sign sand the haemoglobin concentration revealed hypovolemic shock and the patient underwent a laparotomy.

A large haemoperitoneum was found, caused by a ruptured left tube and a salpingectomy was also performed.

In the post operative period the patient had 8 units of cross-matched blood transfusion.

The histology confirmed the ectopic pregnancy.

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The woman was discharged on the 15th post operative day with a pregnancy test still strongly positive (HCG = 19.000 iu/24 h).

The intrauterine pregnancy was uneventful and the patient later had a spontaneous vaginal delivery at 38 weeks.

The baby was a female, 2550 gr. in weight, with multiple malformations and she died 2 years later.

We should mention that the patient and her husband were first cousins.

CASE 2

In January 1992 a 32 year old woman was admitted to the gynaecology ward complaining of pelvic pain and five weeks amenorrhea.

She had had no prgenancies in the past, because of chronic anovulation and she was actually on Clomyd (50 mg a day from the 5th to the 9th day of cycle).

The vaginal examination revealed a normal sized, but soft uterus and a tender right adnexal mass. No bleeding p.v. and no cervical excitation were present.

The ultrasound scan, abdominal and transvaginal, showed a small complex mass in the right adnexum, scant free fluid in the Douglas pouch and no gestation sac in the uterine cavity.

The pregnancy test was positive.

The general conditions of the patient were good, all the parameters were stable and the pain settled spontaneously.

Nine days later, at 7 weeks of amenorrhea another u.s. scan was arranged, showing a small

gestation sac in the uterus, while the adnexal mass and the amount of the free fluid were unmodified.

Three days later the clinical situation suddenly changed, the pelvic pain increased and the haemoglobin concentration dropped.

A laparotomy was decided and a ruptured ectopic tubal pregnancy found, and a right salpingectomy performed.

The patient was discharged 7 days later, with the βHCG high (166.000 iu/ml) and with an embryo pole present in the gestation sac.

The pregnancy was uneventful till term and healthy female baby of 3920 gr was delivered, normally, at 40^{+5} weeks.

We should point out that patient and her husband both had a strong family history of twins.

DISCUSSION

Nearly 15 years divide our two cases but neither the Beta HCG assay nor the use of the u.s. scan, not available in our unit in 1978, together with a more conservative mentality helped us to score a better result.

A well timed laparoscopy allowed us to preserve the tube in the 2nd case, but the misleading clinical picture together with the u.s. scan reports, not ruling out a cystic corpus luteum in the adnexal mass, caused us to choose a «wait and see» policy.

As already stated by others [1] the more frequent presenting symptoms and signs in this situation are:

a) lower abdominal/pelvic pain;
b) adnexal mass;
c) peritoneal irritation;
d) enlarged uterus.

The vaginal bleeding is a controversial and equivocal sign, usually presented by the intrauterine gestation but being reporter in only 30% of cases [1].

In a 1993 report [2] the possibility had been supposed of a sort of subchorionic seepage of blood from the tubal pregnancy.

Only one of our cases complained of slight vaginal bleeding.

The world incidence of simultaneous pregnancies is considered to be one in 30,000, but Reece reported a surprising 1:8,000 at his institution [1].

Several factors could be contributory:
- family history positive for twins;
- ovulation inducing drugs;
- PID.

The only factor not present in our 2 cases was PID.

Congenital malformations and mental ritardation are increased among such newborns [3], probably, as a hypothesis caused by serious gestational hypoxia during the haemoperitoneum.

We had, indeed, one severely abnormal baby from the patients transfused, but this is suspicion and needs further data.

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Address reprint requests to:
M. GRAMPA
Dept. Ob./Gyn., Firm B
Ospedale di Circolo di Varese
Viale Borri, 57
Varese (Italy)